NEW YORK STATE DEPARTMENT OF HEALTH

Office of Quality and Patient Safety

SPARCS Limited and Identifiable Data Request Form

E-mail completed application to:
sparcs.requests@health.ny.gov

SPARCS Operations
Bureau of Health Informatics
New York State Department of Health
Corning Tower, Room 1970
Albany, New York 12237

Phone: (518) 474-3189
Website: http://www.health.ny.gov/statistics/sparcs/

FOR DOH USE:

Request Number: _____

Date: _____

Please refer to the "SPARCS Limited and Identifiable Data Request Form (DOH-5132) Instructions" for guidance on completing this application. Please note that unless a question explicitly states "limited only" or "identifiable only," it pertains to both file types.

File Type Requested: ☐ Limited   ☐ Identifiable

1.   ORGANIZATION AND INDIVIDUAL REQUESTING THE USE OF DATA

A.   PROJECT DIRECTOR

Name, title, phone, and e-mail:

_____

_____

B.   ORGANIZATION NAME

Include specific department or unit:

_____

_____

C.   ORGANIZATION ADDRESS

Street, city, state, and zip:

_____

_____

D.   CONTACT PERSON

Name, phone, and e-mail (if different than Project Director listed in 1.A):

_____

_____

| E. | TYPE OF REQUESTOR |

Check all that apply:

☐ Student researcher, if used for a course or your curriculum (e.g., dissertation/research paper)

☐ Non-profit organization (include your tax exempt ID #)

          _____

☐ Private company/corporation

☐ Article 28 Facility

☐ Federal, NY State, or NY local agency

☐ Out of State agency

☐ Other

       _____

2. NATURE OF REQUEST

| A. | TITLE OF PROJECT |

_____

_____

| B. | PRIMARY REASON/PURPOSE, OBJECTIVE, AND BENEFIT |

_____

_____

_____

| C. | TYPE OF REQUEST |

Check all that apply:

☐ Epidemiological

☐ Financial

☐ Health planning and resource allocation

☐ Quality of care assessment

☐ Rate setting

☐ Research studies

☐ Surveillance

☐ Utilization review of resources

☐ Other
_____

D. DATA REQUESTED

1. **Data Type and Years Requested**. List calendar year(s) requested for each data file. For available years, please refer to the SPARCS Limited and Identifiable Data Request Form Instructions.

Data Type	Year(s) Requested
☐ Inpatient	
☐ Outpatient	

2. **Data Updates.** Will you require periodic updates of the dataset?

☐ Yes ☐ No

If yes, select frequency: ☐ Annual   ☐ Semi-annual   ☐ Quarterly   ☐ Monthly

3. **HIV/AIDS and Abortion Records** (identifiable only). These records have been redacted to the standard of the HIPAA "Safe Harbor" provision, which eliminates all direct and indirect identifiers. All elements must be justified in the Data Element section on page 8. Abortion records will only be released if the request is accompanied by an approval letter from the New York State Commissioner of Health.

HIV/AIDS Records (identifiable requests only):
Are you requesting non-redacted HIV/AIDS records?

☐ Yes ☐ No

Abortion Records (identifiable requests only):
Are you requesting non-redacted abortion records?

☐ Yes ☐ No

E. PROTECTION OF HUMAN SUBJECTS (IDENTIFIABLE ONLY)

Do you have Internal Review Board (IRB) approval? See instructions to determine if IRB approval is needed.

☐ Yes (attach a copy of the approval to this application)
_____

☐ No (enter date submitted) _____
_____

☐ Not Applicable

3.	SUMMARY OF PROPOSAL

A.	RESEARCH METHOD (IDENTIFIABLE ONLY)

_____

_____

_____

B.	CELL SIZE

The Department follows the same small cell policy as Centers for Medicare & Medicaid Services, which stipulates that no cell (e.g. admissions, discharges, patients, services) 10 or less may be displayed. Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell 10 or less. Please describe your small cell size policy below.

_____

_____

_____

_____

C.	LINKAGES

Will you be linking SPARCS data to New York City or New York State Vital Statistics (indicate which files, and submit approval for each)**?**

☐ NY City Birth   ☐ NY City Death   ☐ NY State Death

Will you be linking SPARCS data to any other data source**?**

☐ Yes   ☐ No

If yes, please describe the source(s) and the output file:

_____

_____

_____

_____

4. CONFIDENTIALITY OF DATA

If granted permission to use SPARCS data you must follow the security guidelines as set forth in the instructions, as well as those stated in the Health Information Portability and Accountability Act (HIPAA). By signing, you agree that no attempt will be made to identify any specific individual for whom data are supplied.

A. DATA SECURITY

Describe the safeguards that exist or that will be implemented to ensure the SPARCS data is kept confidential during processing and storage. Submit an initialed and signed Security Guidelines document. The document can be found on the public website at the following address: http://www.health.ny.gov/statistics/sparcs/forms/.

_____

_____

_____

_____

B. CONTRACTORS/EXTERNAL PROJECT PARTNERS

Identify any contractors, or external project partners, and their role. These parties must have an approved SPARCS Organizational Data Use Agreement (DOH-5132OA) on file.

_____

_____

C. DATA STORAGE

Will the data be stored at a location other than with the requesting organization?

☐ Yes. A separate organizational affidavit is required, along with a description of how the data will be protected and secured.

Name of organization: _____

☐ No

D. DATA RETENTION

You are required to destroy/return all data and derivatives at the end of your project or date of expiration. Upon completion of the project or expiration of the data, you must submit a certification of destruction letter. By signing this application, you indicate that you understand and agree to abide by these requirements.

☐ Check this box to indicate agreement

A written request for approval to extend this time period beyond the date of expiration may be submitted to sparcs.requests@health.ny.gov.

E. DATA USE AGREEMENT (DUA)

SPARCS data may not be release to anyone without approval, and you are required to keep patient identifiers confidential. In addition, this data can only be used for the purpose(s) contained in this application.

In the table below, identify each individual who will have access to the dataset(s), including the names of contractors, or external project partners. Should you wish to add new users to this project after it has been approved, please send an e-mail request (including the individual DUA) to sparcs.requests@health.ny.gov.

Only those listed below (with a DUA on file) may access the data.

Name   Affiliation

_____

_____

_____

_____

F. RELEASE OF DATA

Do you intend to disseminate information derived from the SPARCS data or re-release the data to any project partner(s)?

☐ Yes   ☐ No

If yes, how do you plan on releasing information? Check all that apply:

☐ Disseminate information   ☐ Re-release the dataset

To whom will the information be released?

_____

Describe what will be released and in what format.

_____

_____

_____

Unless approved by the SPARCS Data Governance Committee, you are prohibited from releasing identifiable data elements.

5.	SIGNATURES

Project and Organizational Representative

I understand that while data is in my possession SPARCS maintains the right to request quarterly statements describing how the requested information has been used, descriptions of any and all releases of the information including identification of who received the information, data elements released, and purpose of the release.

By signing below, I am attesting that this data will be used for the sole purpose(s) indicated in this application. The identifiable or limited data will not be shared with any person or entity not covered by this application and in no way will we attempt to identify individual patients using SPARCS data.

A. PROJECT DIRECTOR

Signature of Project Director: _____
This person must approve all individual DUAs.

Printed Name and Title: _____

If you are a student, please have your professor, or advisor, sign below indicating that the data is needed for a course, or your curriculum.

Signature and Title of Professor or Advisor: _____

B. ORGANIZATIONAL REPRESENTATIVE

Signature of Organizational Representative: _____
Must be authorized to legally bind the organization.

Printed Name and Title: _____

6.   IDENTIFIABLE DATA ELEMENTS

Please refer to the Data Dictionary on the Department of Health's public website for additional SPARCS data element information.

SPARCS Data	**Justification**
Dates. Includes all dates other than patient date of birth.	
Patient Date of Birth	
Patient Address. Includes entire patient address.	
Patient Record Numbers. Includes all numbers other than policy number.	
Policy Number	
Unique Personal Identifier (UPI)	

PRI Data	**Justification**
Admission Date (day)	
Patient Numbers	
Patient Date of Birth	
Patient Name	
Social Security Number	

PRI data was collected for nursing homes from 1986 through 2005. It does not include a Unique Personal Identifier (UPI). Please e-mail sparcs.requests@health.ny.gov if you would like access to this file.